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ABSTRACT

This series of papers discuss the application of an androgynous model of mental health within the context of a clinical training team. These papers (1) review some of the literature on androgyny; (2) examine the theraputic tension created by the authors' position between cultural stereotypes and their androgynous vision; (3) detail implications of related issues for the client-therapist relationship; (4) examine problematic aspects on moving from polarized to integrative concepts on understanding a client; (5) present alternative thoughts on nurturance and dependency in women; and (6) present applications of the authors' thinking to mental health consultation and their team interaction. (YRJ)

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The Process of Sex-Role Integration In Psychotherapy

Introduction

Alexandra G. Kaplan

> "We have to make ourselves not as a projected ideal, but out of the shapes of the here and now. The barriors which confront us are real, not merely the conjurings of our imagination."

Sheila Rowbotham's words capture the thrust of the papers we will present today, as we share with you our year-long struggle to apply an androgynous model of mental health within the context of a clinical training team. "We" consists of 7 graduate students who will be presenting papers, and myself, the faculty supervisor. The stuff of which our papers are formed derived from our weekly team meetings; discussions in which we first grappled with conceptualizing the nature of androgyny as a therapeutic goal, and then confronted the obstacles which impeded its full realization. From this shared pool of reflections, each panel member chose an aspect which crystallized an issue of significance for her, and gave form to the paper which she will read today.

The fabric of our papers has been woven from diverse sources; literature on androgyny and dialectics, our own emerging definitions of androgyny, case presentations, and, most significantly, reflections on the intrapsychic, interpersonal and cultural parameters which shape our own persons, as women and clinicians. We did not begin, however, with so rich and so personal a source. Rather, fueled by the enthusiasm of being the first all-women training team at our agency, we plunged initially into theoretical formulations, the content of our work. If we could only specify

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goals and ideals, we would be home free. Our discussions at this point were not unlike much of the writings on feminist therapy. We stressed the need to help women recognize their strengths as well as their areas of difficulty, the importance of women expressing their anger effectively, the concern with avoiding an unduly dependent client-therapist relationship, the benefits of a therapeutic stance that is non-authoritarian, and permitting of some sharing and support, and the value of helping women recognize and exercise their options. To refine these concepts, we turned to the literature on androgyny. We read Bem's work and the papers from the Sex Role Transcendence project at the University of Michigan, and speculated on the clinical implications of these models. In a highly exploratory fashion, we gave the BSRI to all our incoming clients. And then, with cases assigned we set out to become androgynous therapists.

Androgyny, as we have come to understand it, is a multi-faceted term which bears defining before we consider its application. One can conceptualize androgyny in terms of stages along a continuum. At the far left would be traditional sex-role polarities, a pre-androgynous stage. Androgyny would begin with, but not be limited to, Bem's operational definition of the equal presence of masculine and feminine characteristics. It would also include, moving along the continuum, Rossi's notion of "hybrid" characteristics; the sense that an integration of stereotypic masculine and feminine traits could produce such possibilities as assertive dependency, or supportive anger. The expression of traits from one dimension, in other

words, can be tempered by their co-existence with the other. In the papers that follow, differential emphasis is placed on each of these aspects of androgyny. Finally, we would differentiate androgyny from the end point on the continuum, sex-role transcendence, in which these new behaviors become divorced from the stereotypic roots from which they developed.

Our initial encounters with psychotherapy soon revealed to us, however, that the application of androgyny is far more easily said than done. As we slowly and rather painfully began to realize, we ourselves were having unanticipated difficulties in putting our theories into practice. We wanted to highlight strengths, but somehow kept going back to problem areas; we listened for problems with anger, but failed to hear them when they appeared, we became simultaneously more distant from client than we wanted, and more enmeshed with them especially as they showed signs of moving away. The recognition of our inabilities to examplify our ideal, necessitated explorations into ourselves, and into the process, rather than the content of our work Within a dialectical framework, we began to temper theory with considerations of our psychological realities. In Bobbi Fibel's paper, the therapeutic tension created by our position between cultural stereotypes and our androgynous vision is delineated. The resultant search for synthesis along various parameters is illustrated in the remaining papers. For example, one of the major dynamics we encountered was the difficulty of maintaining a strong yet supportive stance with clients in face of our training, as women, not to acknowledge our anger, to use emeshment as a

defense against loss, and to either yield to feedings of inadequacy or hide them under facade of false confidence. Ann Greif details implications of these issues for the client-therapist relationship, which Esther Shapiro exemplifies some of the resultant conflicts that emerged between herself and her clients. We also began to re-conceptualize the nature of our clients' difficulties and implications of these alternative formulations for therapeutic interventions. Mary Anne Sedney shares problematic aspects in moving from polarized to integrative concepts in understanding one client, and Anne McComb explores, through case studies, some alternative thoughts on nurturance and dependency in women. The final two papers, by Lynn Starker and Roz Malmaud, present applications of our thinking to mental health consultation and our team interaction, respectively.

Our use of a dialectical perspective is meant to imply that the problems we encountered are not indicative of "weakness" in the model of androgyny or in ourselves as clinicians, but rather, are inherent in the conflicting strains between self and culture, between theory and experience between content and process, between client and therapist. Wrestling with these conflicts provided the conceptual center from which much of our thinking, and ultimately our growth, derived. Our purpose in reflecting on dialectical struggle is to move our consideration from goals to process, from theories to the substance of our clinical work. Our initial formulations, we remind ourselves, are but themselves part of a continuing process of increasing clarity and conceptual sophistication. Again

listening to Sheila Rowbotham:

> "The creation of an alternative world cannot be the work of a day. It is hard to steer any steady course while accepting that we will always aspire beyond what we can realize. It is hard to put out our hands and touch the past, harder still to bring the past into the future. But we will have to discover our own reality, too, or we will simply be subsumed."

Transcendence of Sex Roles: Parallel Cultural and Psychotherapeutic Change Process

Bobbi Fibel

Psychologists are increasingly cognizant of the extent to which the process of psychotherapy is embedded within an ongoing socio-cultural context (Coan, 1973; Buss, 1975; Riegel, 1972). Nowhere is the dynamic interplay between the psychologist and her/his culture more cogent than in feminist psychotherapy. As members of the culture at large, therapists are inheritors of a cultural history in which sex roles are stereotypically polarized--masculine versus feminine. The individual therapist has, in some varying degree internalized the norms, attitudes, prescriptions, and proscriptions for role-related behavior. Idiosyncratic personal histories notwithstanding, objective success within academia is testimony to such socialization influences. Further, the therapist in the course of interacting with a social milieu acts upon prevailing interpretations of reality. We are then both the changer and the changed.

Typically, we women therapists have awarded ourselves the label "feminist" as a diploma from the school of sexist hard knocks. Most often we collectively presume to have graduated from the sexist constraints on professional functioning. In doing so we run several risks. First, we distort a cultural context which confronts us, in this moment of history, with a multiplicity of sex role dicta. Our faculty demand rigor, productivity, expertise, assertiveness. Our clients expect wisdom, sensitivity, insight, compassion. In our intimate relationships we must offer nurturance, responsiveness, reliability. To deny the transitional, often conflictual nature of these expectations is to perpetrate psychotherapeutic

fraud. The danger clinically is monstrous for we risk, in androgynous elitism, invalidating our clients' socially-sustained, experiential sense of conflict. Simultaneously, we shun the challenge to our own personal and professional development. In its most innocuous form, we retard a workable redefinition of roles and an effective translation of psychological theory into therapeutic practice. Crucial then is a conceptual framework which acknowledges our cultural and developmental heritage, does justice to the reciprocity of the clinician-client relationship, and captures the dynamism of the process of restructuring stereotypical sex roles.

Toward such a formulation, a dialectical perspective is compelling. In this model, change and growth occur as a result of creative synthesis of inherent polarities. The resolution of physiological, psychological socio-cultural conflict is transitory so that even the present resolution comes to serve as the basis of yet another conflict in a teleological progression through moments of history. A dialectical approach, then is suitable for and enriching of our therapeutic perspective, for it understands the individual in relation to her/his historical context and embraces contradictions in consciousness. Further it is best understood, as is therapy, as an interactive process and therefore only fully explicated by working through particular content or issues, as subsequent papers in this symposium will do.

Rebecca, Hefner, and Oleshansky (in press) proposed a three stage developmental model of sex-role socialization which incorporates the

dialectical model. In Stage I the individual holds an undifferentiated concept of sex role. Later, the belief is modified by physiological and cognitive maturation as well as through interaction with the physical and social environment. The child learns thereby the distinction between male and female. Furthermore, the young perceive that certain behaviors are considered differentially appropriate and valued depending on one's sex. This process culminates in Stage II, the polarization of sex role concepts. Emergent in the second stage is the active acceptance of one's stereotypical masculine or feminine role and active rejection of the opposite pole. The transition to Stage III, the transcendence of rigidly sex-typed norms of behavior, cognition and affect marks the beginnings of a dialectical mode of being-in-the-world. One becomes oriented toward movement, flux, and dynamism so that even the immediate transcendent resolution is temporary, attendent on new crises. Rebecca (in press) noted, however, that while movement from the first to the second developmental stage is supported by complex cultural forces, little or no support is provided for the individual in the second transition. The feminist psychotherapist must operate then as an agent in the service of transcendence. Her role is to support if not catalyze the process of transition.

I have earlier alluded to some impediments to fulfilling this function unambivalently. Viewing the therapeutic relationship as a microcosm of the larger existential reality, the individual client and therapist bring to the relationship all the cultural baggage operative in other interpersonal contexts. Although these may be highly particularized, feminist psychologists as a group generally face a common set of professional issues. Personally,

because we are women who have attained high levels of academic achievement, we have likely subordinated personal concerns in ways that are atypical for women. Alternatively, ordinarily unquestioned patterns in intimate relations, social relationships, marital and familial relationships become conscious, explicit choices. Professionally, identifying oneself as a feminist remains in most instances, an act of courage. Within a discipline still working to establish its legitimacy in the eyes of the public, radical therapy is threatening. More subtle, though no less threatening, the feminist politicizes institutional policy by her very presence. She poses a challenge to the existing male-dominated structure. The effort to defend her ideological commitment and wage the intellectual and political struggles encountered is taxing. Embattled as we are then, we cannot expect of ourselves to respond conflict-free to the sex role issues our clients present. These conflicts represent the emergent culturally conflictual elements which constitute the content of feminist psychotherapy. It is the intersection of these conflicts with the therapist's own which is the opportunity for mutual growth or stagnation. Requisite then is a therapist's continual re-evaluation of current sex role integration.

On the other hand, our clients reflect, generally speaking, a more heterogenous set of concerns. Less often than ourselves they enter the therapeutic relationship not with political consciousness, but via painful life circumstances in which they identify themselves as culpable. Even those who are feminists locate the problem in their own deficiences by the very act of seeking therapy. Inherent in the cultural understanding of therapy is the role of expert assigned to the therapist. Historically, the power of the role was buttressed the stereotypical male therapist - female client dyad.

The role itself now implicitly embodies this power relationship. The feminist therapist comes then to represent for the client not simply the potentiator of resolution, but also confirmation of the client's inadequacy. At the outset then the feminist psychotherapist faces an arduous task of reorienting the client while herself trapped between the Scylla of establishing professional competence and the Charydbis of destructive self-aggrandizement. The potential therapeutic tangle can only grow more complex as the relationship progresses toward increasing intimacy for here we are most vulnerable to imposing our personal resolutions instead of encouraging our clients' autonomy.

The dialectic mode is then most exigently required. The therapist must remain in dialogue, privately or otherwise, with the ways in which the client elicits a polarized response - one which calls forth on her part rigidity, intolerance, impatience, or distress. We must ask ourselves, to what new source of conflict does this client speak? In what ways do her circumstances intrapsychic, interpersonal, or cross-cultural, parallel conflicts in our own lives? Even more crucial to our clinical functioning is the question - how do we help our clients work through, integrate, and transcend our own developmental moment?

Dialectically we are obligated to do this by confronting ourselves with the same questions we confront our clients. The process of psychotherapy, then, like the process of cultural transition, is in large part a bootstrap operation. The client's potential for growth is not so much limited by the therapist's point of personal development along the continuum toward transcendence as by her willingness to permit herself to change vis-a-vis the client.

Therapy from this perspective is a mutual odyssey through uncharted territory in an era in which the cultural winds may blow at once favorable and unfavorable. The energy for such an enterprise must be continually replenished. Curiously, while we take for granted the desirability of support networks for clients we often overlook our own pressing needs. We cannot function effectively in professional or personal isolation. In our attempt to be recognized as independent and competent we often fail to provide a supportive work environment. The solitary feminist therapist is then impelled toward a competitive male model of professional identity. This can only end in perpetuating sex role polarization in which masculine modes are overvalued. We must instead draw on the lessons learned from the women's movement - Sisterhood is Powerful.

A feminist support network serves a dual function. It provides a forum for shared experiences which maintains the individual in dialogue with a larger community, and sustains her through crises she faces in a world giving her mixed messages. Second, it is the active means by which a therapist, faced by her clients with the limitations of her own immediate resolutions, can reintegrate and ultimately transcend her experience. The network is both a vehicle for personal growth and a safeguard against impeding clients' growth either by circumventing thorny issues or worse, burdening clients with one's personal concerns. In short, the therapist must capitalize on the meagre support for their own transition from polarization to transcendence to effect change in clients and culture. The process is never linear, but rather spirals, alternately powered by our strengths and vulnerabilities.

The psychological community, being at once self-conscious and socially-conscious, frequently magnifies for the feminist psychotherapist the dichotomy between masculine/feminine, personal/professional, private/public. The resolution cannot be separated from the context in which it grows. A dialectical framework orients us to the sources of conflict and the necessity to look beyond our immediate individual understandings toward a social synthesis.

Complexities in Conceptualizing Clients' Problems in Androgynous Terms

Mary Anne Sedney

I began this year of clinical work fresh from an internship and eager to integrate my strengthened clinical skills with some of the ideas Sandy Kaplan (1976) advocated regarding issues for women in therapy. The feminist aspect of our team's plans excited me because it seemed to provide the possibility for articulating and applying a model with a sex role perspective on clients' problems. At that point it seemed that writers on androgyny--Sandra Bem, Janet Taylor Spence, Jeanne Humphrey Block--held the greatest promise as sources of direction in this area. It seemed a fairly simple task to take their ideas of androgyny, phrase them in practical terms, and help clients to develop in that direction. I had visions of working with formerly sex-typed clients to develop the "missing half" of their abilities and skills.

I learned rather early that it takes more than good intentions to turn the ideals of androgyny into actual good therapy. I have come to the conclusion, however, that the problem goes beyond the classic "ideals vs. reality" dilemma. Struggling with issues involved in this translation has led to a recognition of some critical problems with current conceptualizations of androgyny, and a recognition of some necessary steps in developing androgyny beyond a framework of polarities.

For me, these issues have been most clear in attempts to conceptualize one client's problems in sex-role terms. Using as data a journal I kept over the nine months (25 sessions) of work with this client, I have succeeded in highlighting some of the major points.

In developing these conceptualizations, I have found the work of Hefner, Rebecca, and Oleshansky (1975) instructive. They articulated three stages in the process of sex role development: an initial undifferentiated view of sex roles, followed by a second stage of polarized sex roles, and a third stage of sex role transcendence. In applying their developmental framework to the process of therapy and my changing conception of the client, several slightly different stages in my own thinking became apparent. I began at the stage of polarized thinking about sex roles and developed from there to what might be labeled a dualistic stage of thinking. A third stage of real integration seems desirable. To me, the addition of dualistic and integrated stages between the polarized and transcendent stages enriches Hefner, et. al.'s model and has implications for conceptualizations of androgyny as currently presented and operationalized.

Stage 1: Polarities

In my initial work with the client (a 53 year old woman who referred herself to therapy because of difficulties in her relationship with her husband) my words describing her were a pendulum: weak, then strong and then back to weak at the slightest hint of trouble; sad then angry; moving too slowly, then too quickly. It seemed that in this initial stage, I could see only one part of a dimension at any one point in time, and she could perhaps present only one side of herself at a time. In my eagerness to escape rigid sex-role conceptions, I was swinging between opposites, never able to settle on an articulation of her problem that

lasted longer than a few sessions. For example, after the first session, I wrote about her, using words like "inability", "unwillingness", "indirect" expressions of anger, "immobilization", "indecisiveness". I assumed she was remaining in an unsatisfactory marital relationship because she felt unable to make it alone. It was a list of psychological "bad names." Trying to view the problem in sex-role terms immediately led to the assumption that she fell at the extreme, "femininine" end of the scale. I ignored the other information she gave about herself, including that she had recently climbed a mountain to test out her new plastic heart valve, that she had come to some decisions about the relationship, involving the articulation of some demands to her husband. Even as she described the coping tactics she used I thought "How feminine and passive they are." But, after several sessions I had changed my view and was using words like: "strengths", "independence", "ability to confront and recognize her anger", " an incredible woman", while berating myself for "holding her back", and being "a few steps behind her". In short, I was expressing delighted amazement at her strength, flexibility, and independence. A few weeks later, though, words like "panic", "inability", "pain", "difficulty", and "dependency" reappeared. This process was repeated several times, as the strengths or weaknesses predominated in nearly alternating sessions.

It seemed that, in my attempts to abandon the old rigid polarities of masculinity-femininity, I remained their prisoner: as I struggled out of one polarity, I fell into another. At this point, I could only hear/see one thing at a time.

In part this may have been due to my polarized eyes and ears--as a product of a culture that emphasizes clear sex-role dichotomies as the ideal, I was accustomed to thinking in terms of either/or: people are female or male, feminine or masculine, young or old, strong or weak. But I think part of the problem can also be attributed to the framework of androgyny in which I was attempting to work.

With the androgynous "ideal" before me, I was using concepts based in sex-typed words. Authors described androgyny as the presence of both masculine and feminine qualities, so I looked for both. I was so eager to "temper masculinity with feminity" (Bem, 1975) and "mitigate agency with communion" (Bakan, 1966) that I was involved in a near-continual search for the "missing half". As soon as I observed one dimension, I ran off in search of the other, thus losing hold on the first. Essentially, I was blinded by the terminology; still trying to fit these new concepts into the old words that form their definitions.

Stage 2: Dualities

This pattern was repeated so often that I could not ignore it. In confronting the inconsistencies in my thoughts about the client, I first tried to decide one way or the other: is she strong or weak? Realizing that that was not possible led to an acceptance of the simultaneous presence of opposing tendencies within the client. Thanks to Sandy's supervision and the client's own reality, I began to see the issues in less oppositional terms. Through great effort I was able to hear the current

week's reality while retaining images/memories of last week's, when the other side of the pendulum had been presented.

This, my current stage of thinking, might be labeled dualistic. I retained the cumulative recipe for androgyny, however: a little masculinity plus a little femininity, spread over time, with each emerging according to the situation. Such a view is consistent with the example offered by Hefner, et.al.: a man who one year, in searching for a job, is assertive and independent, yet nurturant and protective in the years when his children are small. Bem's (1976) androgynous subjects who can both laugh when others don't and be nurturant with kittens and babies were further manifestations of this level of androgyny.

Thus, if the client presented herself in one session as depressed, lonely, and helpless, I was able to talk with her about those things while remembering that this was the same woman who, at other times, climbs mountains, leaves her husband, and makes steps to building a new life for herself. Without denying her feelings of weakness I was able to fit them into the picture of strength that had emerged in other sessions. While my initial unstated goal for the therapy was arrival at some decision about the marital relationship, I was able to be comfortable with the therapy ending without a definite decision. I could accept her ambivalence about her husband, as well as her statement that she had to move toward a decision one step at a time, at her own pace. We focused on the dualities in our therapy relationship too: our similarities as well as our differences, the anger as well as the caring, the neediness alongside independence. In short, the framework for conceptualizing the therapy had broadened so

that I was no longer locked in a swing between rigid polarities. This recognition of the simultaneous presence of heretofore-thought opposing qualities is consistent with current notions of androgyny.

Stage 3: Integration

Nevertheless, it is clear to me that this is not an actual integration of polarities. True, I've learned to moderate them; I no longer rely so heavily on polarized, either/or descriptions of the client. But even the dualistic solution I've arrived at is unsatisfactory. As long as androgyny is viewed as the simultaneous presence of two traits, an awareness of any one of these qualities in a person or situation makes one anxious about the other; thus the swing to the other end of the dimension.

Instead of embracing androgyny as the new ideal trait, we need continued attention to the process of integrating apparently contradictory qualities. While looking ahead to the "withering away" of sex role conceptions into transcendence, we must recognize that at this point we have neither the language nor the models to even recognize sex-role transcendence. Perhaps discussion of another intermediate stage, that of sex role integration will facilitate movement in that direction.

For example, what is the integration of agency and communion? Anger and sorrow? Strength and compassion? What do they look like?

Some hints regarding this integration of opposing tendencies emerged in the work with my client. Following our final session, I received a warm note of appreciation from her. This was especially striking because several months earlier she had spoken of having wanted to make a similar

gesture to a friend who was leaving town but did not have the nerve to actually send the note. At another point in the year, she tacked up a curt, angry note on the wall at work demanding that no one smoke cigarettes anymore. One might think of the unsent note, the warmth that she never expressed, as the traditional feminine sex role in its inappropriate extreme: lovely emotions but without the assertiveness to communicate them. Her second note, on the wall and directed to smokers, might be seen as another extreme: so agentic and assertive that everyone became angry at her and they refused to consider her request. Again, inappropriate. In the note to me, she managed to integrate those poles in a single action: one that could be called assertive warmth.

This is a simple example of the type of combination behavior that would be apparent in an integration stage of sex role development: not old-style masculinity in one situation and old-style femininity in a different situation even though the sum would be androgyny by some measures. I would prefer to see our theories and research examine a wide range of new behaviors in an effort to both recognize and facilitate genuine change. Perhaps in doing this we will be better able to move toward transcendence, when the old terms of sex roles will be rendered meaningless.

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Developing the Nurturance Needs of Independent Women in Psychotherapy

Anne L. McComb

I have seen a number of women in therapy who are doing well academically or in a career. They seem to have broken away from traditional women's roles of housewife and "the woman behind the successful man." However, they have real trouble accepting their legitimate dependency needs and feel unable to ask for or accept nurturance and support for themselves. This year I became familiar with the concept of androgyny as defined in our symposium. As I began to think about my women clients who had had trouble asking for and accepting nurturance, from the perspective of androgyny, it became obvious that these women were using sex-typed behaviors, both masculine and feminine, but could in no way be considered androgynous. That is, at times they were self-reliant and stoic while at other times they were dependent and submissive, but rarely were these traits integrated or used in a situationally-appropriate fashion. Using the concept of androgyny as a model of mental health, as a structure in which to think about my previous and current clinical work, I found that my clients' developments and therapeutic progress, and the goals of therapy came much more clearly into focus. From this perspective, I will describe these clients and their development of a counter-dependent style. The goals and the form of therapy implied by such a perspective, as well as larger implications for our culture will be discussed.

These women were very ambivalent about entering therapy. They felt that they should be coping by themselves and were angry with themselves for

needing help. They had little perspective on the emotional disruption caused by their major life-changes, and were annoyed that they were having trouble dealing simultaneously with these changes, full courseloads, and demanding jobs. One such client, Colleen, had just returned to town after a four-month, promising separation from her husband, only to find her situation with him unchanged. He did not want the relationship, but could not let go of it. Colleen was a 30 year-old undergraduate who also worked much of the time as a waitress. Like many of my women clients, she tended to push herself to do everything at once and found it hard to give herself support in ways such as cutting back on school work or letting a divorce decision ride until other pressures let up.

As I listened to bits and pieces of the women's childhoods, an interesting pattern emerged. Each woman had experienced a mother who had pushed her to "do it yourself." One client regularly took a train alone across Chicago at age seven. Another began cooking meals for her family at age six. There was little parental support for the client when she complained of being frightened or unhappy; she was told that she was being selfish and a burden. In one case, the client heard over and over how her mother had never wanted children and how troublesome they were to take care of.

In this way my clients' upbringings were remarkably similar to those of men. Like little boys, they were encouraged to take care of themselves, not to ask for much nurturance from mother, and to wear a rather stoic front, belying their needs for warmth and comfort. However, unlike most

male children, my clients also received explicit messages that they were to nurture their own parents. The same mother who delegated the responsibility for the family's dinner to her six-year-old daughter also complained bitterly that her daughter did not care for her. On Saturday, Colleen's only free day, her mother would assign chores that could easily be done another day. When Colleen finally finished the chores and wanted to go play with friends, her mother would whine that Colleen never wanted to spend time with her, until Colleen would give in and spend Saturday at home. Thus, not only were her dependency needs largely unmet, but her strivings for appropriate autonomy were thwarted also. The child's only way to feel connected to her parents was to go to the extreme of dependency (submitting her own to her mother's needs by staying home to take care of her) or the extreme of independence (asking for little of the support legitimate for childhood). In addition to parental messages, these clients were subject to a strong cultural message. As children, the women learned that a woman's role involves taking care of others and submitting one's own needs to those of husband and family.

Even though these women were raised with traditionally masculine characteristics of self-reliance and feminine characteristics of nurturance and submissiveness, within this concept of androgyny, they cannot be considered androgynous. As we shall see, their masculine and feminine traits are not integrated and often surface at inappropriate times. Too often the women react with either extreme of sex-typed behavior.

For many of these clients it has been a long struggle to become indpendent in the sense of having a life and career of one's own. Since their dependency needs were ignored from childhood on, they report feeling in a perpetual state of neediness. They have attempted to satisfy these needs, not by assertively asking others for support (an integration of assertiveness and dependency), but by staying at home to take care of a husband or family, fearful that if they did not do so, none of their dependency needs would be met. These women, when I met them, were being forced to find new ways of meeting their own needs and were fearful that none would appear.

Perhaps it is because these women learned to do things on their own (however inappropriately) with little support from others that they have begun to succeed in the male-oriented world of careers and higher education. Yet since this world is still rife with traditionally masculine values of self-reliance and "toughing it out," women functioning there are clearly reinforced for not asking for emotional support. Thus, instead of tempering independence with requests for support, they buy into the traditional masculine ethic of being self-reliant at all costs.

Further, having been taught as children that to be dependent was to be rejected, many women heard the call for independence of the women's movement as a call for counterdependence, to have no dependency needs. Yet since our culture is in a period of transition, the women are still mindful of their previous lessons that a woman's job is to take care of her husband when he comes home, drained from the competitive work world. Such a woman

is not just in the bind of having received double messages from her parents ("do it yourself" vs. "don't leave us") but also of receiving conflicting messages from our culture ("stand behind your man", "stay at home with your children" vs. "be independent", "go back to school", "get a job", "fulfill yourself").

Thus these women enter therapy reflecting in their personal conflict, a culture in conflict as well. Instead of responding to parental and cultural messages by integrating the healthy aspects of independence and dependency, i.e., fulfilling oneself and nurturing one's spouse, the women have reacted by going to one extreme or the other. These women usually enter therapy at a time when they are attempting to be extremely self-reliant. Finding that their needs for nurturance were not met by being submissive and dependent, they have bounced to the other extreme and are finding themselves equally unhappy at that extreme.

As a therapist working from an androgynous perspective, I keep in mind the following therapeutic goals:

1. to help each woman realize that a need for nurturance and support is a valid human need and not a sign of weakness or selfishness.

2. to develop with her appropriate ways in which to ask others for support and nurturance.

3. to help her learn appropriate ways to nurture herself so that her needs do not become overwhelming. When support is not forthcoming from the environment she can provide it for herself.

4. to teach her that assertiveness and independence do not preclude asking others for help, that it can be a strength to trust others enough to ask for their help.

5. to help her integrate her dependency needs with her needs to be her own person in a way which allows her to be appropriately dependent, yet to have her own thoughts, feelings, life's work.

Thus, from an androgynous perspective, I would advocate the integration of dependency and independence, choosing the healthy aspects from both the dependency women learn so well and the independence which men assimilate.

When I sense that a client comes in to work on these issues, I try to give her the space that she needs while maintaining my presence as a person who cares for her. I let her determine our interpersonal distance which usually allows her to trust that I won't force her into what she sees as a one-down position of needing help. As this trust is gained, we begin to discuss her need for more support and the difficulties she has in asking for it. Often her anger at being in this vulnerable position masks her early attempts to ask for what she needs. In one case my client was very assertive in being angry with me. However, it was clear that her anger with me was more a function of her fear of losing control over her needs than a response appropriate to the situation.

The desperation and crises with which these women enter therapy allow them (barely) to overcome their fears of this act of asking for help. However, when they come in needing help so immediately, feeling totally unable to cope, it reinforces their own and others' views of them as hysterical, helpless women. I encourage each woman to learn to ask for help or support <u>before</u> she feels so desperate, so that she may experience asking when the stakes are not so high. This allows her to ask from a

position of strength. If someone must say "no" to her request, she need not feel crushed; she, at this less desperate point, still has the resources to turn elsewhere or to look within herself for the support she needs. By practicing making her needs known when she is not in great turmoil, she can begin to choose the contingencies under which she will accept support. That is, if she is not desperate, then she does not have to accept help in any form it is offered but may learn to discriminate who will support her, yet let her be herself, from those who require that she be submissive or nurturant to receive their support.

I find it important to offer my clients support from a stance of acceptance of their strengths. I offer, but do not push my help. This allows them to say "No", which is a strength, if only a strength of defense. Further, it seems crucial to label and emphasize what strengths she does have. However inappropriately she has been taking care of herself, she has been taking care of herself. Maintaining any kind of emotional equilibrium while going to school, working part-time and experiencing a divorce is no small feat. When she becomes aware of her own strengths, she is less frightened of asking for support, because she recognizes that she will not wilt if support is not forthcoming. By asking for help with an awareness of her strengths, she learns that she does not need to deny herself in order to accept help.

What are the implications for society of teaching these women an androgynous stance with respect to independence and dependency? Are we helping women when we teach them to ask for the support they need

when they will function in a career world in which these requests are still seen as signs of weakness or incompetence? I believe we are. Perhaps, career women in asking for and receiving the support which they need, will avoid the high blood pressure, the heart attacks and the ulcers that are an accepted part of the competitive work world.

Further, it has always been expected that a man's home and his wife were there in large part so that he could come home from "a hard day at the office" and obtain the emotional support he needed. This kind of "home" and "wife" are not built in for the working woman, so she must learn to ask for support from those with whom she works, friends, and relatives. And, as women perform less solely the nurturing role, move into the work force, and thus need more support for themselves, men will have to learn to ask for it both at work and at home. As the women change, so they become agents of change in a continuing dialectic between psychotherapy and culture.

At this point, however, our culture has hardly heard of androgyny, much less accepted it, and I find myself and my clients frustrated in the tension between our new roles and a culture which does not yet embrace them.

Developing an Androgynous Perspective Within the Client-Therapist Relationship

Ann Greif

The interpersonal context in which therapy takes place and through which psychotherapeutic change occurs is considered the crucial parameter by numerous clinician-theoreticians (Fromm-Reichmann, 1950; Guntrip, 1971; Sullivan, 1953). Consideration of the therapeutic relationship is a necessary step in the development of any theory having to do with psychotherapeutic change. Thus, when I began seeing clients on a supervisory team, which held up androgyny as a model of mental health, I was confronted with conceptualizing relational issues in new ways. At that point, having come from a psycho-analytic perspective, I had only begun to speculate on what the characteristics of the relationship would be if androgyny was the goal of therapy.

Over the course of nine months of clinical work various dimensions of the therapy relationship have emerged as particularly salient. These include the relative interpersonal distance between client and therapist; the relative power or status differential between client and therapist; and the relative autonomy or individuation allowed for in the relationship.

I can now begin to delineate what at present seems to be the optimal therapy relationship. A dialectical view predicts that in the future this optimal relationship will change in response to other socio-cultural changes. Within the therapy relationship experimentation, risk, life-affirmation and sensitivity to clients' needs are the constants which guide me as I come to appreciate the ever-changing nature of myself, of my clients, of any particular relationship, and of the socio-cultural context.

Traditionally the therapist defined the relationship in such a manner that there was a large interpersonal distance between himself and his clients, that the power remained firmly in his expert hands, and that dependence was encouraged and promoted. A sharp dividing line separated the traditional therapist from his clients. I use the masculine pronoun deliberately here because the majority of my predecessors have been men who saw women clients.

Working within a new model and seeing the therapeutic process dialectically, I have not such safe role in my relationships. A dialectical perspective does not allow me to delude myself into thinking that I am set apart from my clients. We share the power; I am defined by them as they are defined by me; intimacy is worked out in a dialectical process between myself and my clients; and dependency is gradually given up as the clients realize the inherent equality we share.

In our culture these aspects of the relationship encourage a radical restructuring of clients' phenomenological worlds. Sex-role stereotyping has emerged from a culture which stresses interpersonal isolation, status differentials based on arbitrary power or competition, and dependency in women. The therapy relationship, which helps clients to transcend their sex-role socialization, must also transcend the cultural bondage that surrounds our more traditional therapy models. Thus it is consistent with the concept of androgyny to lessen the traditional power imbalance between client and therapist, to move toward greater interpersonal closeness, and to encourage greater autonomy than is typical in more traditional models of psychotherapy. Yet each of these stances contains inherent difficulties to

which the therapist must attend.

As a therapist striving to lessen the power imbalance between herself and her clients, I had to reconcile myself to my strengths, my weaknesses, my fears and my expectations. The differentiation of legitimate authority from arbitrary power was problematic since I was not yet fully accepting of my position of authority in the therapy relationship and was vulnerable to becoming more a peer than a therapist. For example, I was seeing a male client, Robert, who was in his forties. Robert asked early in therapy if he might meet my supervisor. As a novice therapist and as a woman I found it difficult to say "no" to his request, although I clearly saw his request as an avoidance of dealing directly with me and as countertherapeutic. With the support of my supervisor I was able to say "no" and to claim my legitimate authority within the relationship. Ultimately, this decision proved to be very conducive to the establishment of a secure working alliance between us. Robert's tendency to disdain and to sarcastically criticize our relationship and my acceptance of him could only have been explored in a relationship where I was comfortable and secure in my legitimate authority as therapist.

With women clients there were additional hurdles to surmount with regard to power. I feared that women would be extremely sensitive to a woman assuming power; I feared that coming across as competent and secure would threaten a woman client, and that competition would disrupt the therapy relationship. When I first began, I wondered if they had hoped to see a male therapist who, supposedly in their eyes, was more entitled to assume power within relationships and who could serve as a more protective nurturer than I. At that time I felt that women who were having difficulties would

generalize their sense of helplessness and perceive me as a helpless, powerless therapist or as a usurper and a fraud. I was carrying a large burden of self-doubts and fears as I began working with female clients.

To some extent I was right about my fears; competition and my right to power and prestige were issues that emerged in therapy. However, initially the question was much more diffuse, and women clients began by wondering how close we were to be, how much I could understand them and if I could help them. Questions of relative distance between myself and my female clients were the first issues of therapy. Perhaps the sequencing of issues was partially determined by my own level of comfort. It seems likely that I and my female clients have been socialized in such a manner that intimacy is the easier and more readily addressed question with competition, competence and power as less readily discussed dimensions in relationships. For example, with Robert my competence was the initial issue; he asked the intake person that he be assigned to a competent, knowledgeable therapist and we discussed this early on.

Similarly a push for greater closeness must be tempered with the realization that relational closeness in therapy is most easily achieved when the client is suffering and thus may lead to a stress on the client's problem areas rather than on sources of strength. Especially with women encouragement of "helplessness" would only reinforce the cultural role already imposed. Unfortunately for women in our culture intimacy has been associated with dependency. I found that much of the relational work in therapy involved separating intimacy from dependency, and the relational goal of therapy became, for myself and my clients, an intimate sharing based on individuation and autonomy.

This goal was articulated and refined after many sessions of struggle for myself and clients. One woman, Susan, entered therapy with the presenting problem of "inability to relate to self or others." After a rocky first two sessions, during which Susan let me know in numerous ways that she was ambivalent about beginning therapy, her relational difficulties were dramatically acted out with me. Her withdrawal, depression and refusal to engage kept me at a distance which I found difficult to accept. In my efforts to sustain the relationship I persistently sought to draw her out and effectively pushed her deeper into her withdrawal from the relationship. I felt helpless and responded by even more desperate efforts to regain contact. I was feeling the helplessness and desperateness which Susan had earlier described as feelings she had felt in her relationship with her lover. And consistently I violated the space which she was needing, because of my own need to close the gap between us and to live up to my model of therapy.

The loss of autonomy had become equated with intimacy for Susan, and I lost sight of this fact as I struggled to cement our relationship. As a woman I had learned ways to engage, persuade and seduce others into relationships. However, with another woman, especially one who was currently experiencing the helplessness of a dependent intimacy, the female therapist must allow space and time for true intimacy to develop. Too often a false intimacy is quickly established, or clients leave therapy when the establishment of intimacy becomes a desperate struggle. It is well to note that many members of this team worked with women clients who entered therapy with a real fear of helplessness brought about by earlier desperate intimate relationships. Therapists within this model must respect the needed

initial distance which so many clients require. Our clients were people fighting to achieve a vital balance between autonomy and intimacy. At the beginning of the therapy the balance was often precariously maintained and the therapist had to learn to adjust herself in relation to the client in order to secure the optimal autonomy and the optimal intimacy. The goal of therapy in an androgynous model remains a greater relative intimacy than is offered in traditional models, yet the pitfall of quick or pseudo-intimacy which bypasses a secure foundation of client autonomy must be recognized.

Androgyny and Psychotherapy: One Person's Therapist is Another Person's Client

Ester Shapiro

Our clinical team has found it useful to conceptualize therapeutic growth and the exploration of sex-role issues in terms of developmental metaphors. You have now heard Bobbi present the dialectical model, and Mary Anne discuss the model of androgyny. I want to add to these another developmental perspective, Werner's organismic theory of development. I will first describe the developmental process which Werner proposed, and then use its structure as a means of exploring my own development as a therapist. Specifically, I will describe the stages I went through in applying a feminist ideology based on the model of androgyny to my first clinical work.

Werner describes development as a sequence of three stages. In the first stage, one experiences or perceives a global whole, a unified but amorphous outline, with no clear distinction between the self which perceives and the other which is perceived. In the second stage, one experiences differentiation of the whole into parts, and unity is sacrificed for a more precise and distinct perspective of components within the whole. This is often a stage of polarities in which a single component is in exaggerated focus for the purpose of exploration beyond the amorphous whole. In the third stage, the differentiated parts are organized and integrated into the whole. While a first glance at the beginning and end of the sequence would find them similar, the crucial difference is the awareness of and access to the differentiated parts within the whole.

These developmental stages are continuously re-experienced, as one meets new life situations with new demands. Werner sees these sequences as occurring simultaneously at many different levels, ranging from microcosmic perceptual tasks to macrocosmic life-stage tasks. Werner notes that one best adapts to new situations from the global and amorphous first stage, because it is more flexible in its possibilities for re-organization. This creates the paradoxical situation that growth demands regression to earlier life stages in order for the organism to adapt more flexibly to new situational demands. I have found Werner's developmental theory a particularly comforting perspective, because it gives both my failures and my success a growthful direction in a developmental sequence. I will illustrate the way I learned from my mistakes, and the developmental sequence that unfolded, through two cases I worked with on another clinical team during my first therapy practicum.

I began my work by requesting women clients. I had grown increasingly committed to a feminist ideology in my personal and professional work, and held androgynous goals for my own development. I had found feminist consciousness-raising and my work with androgyny to be a catalyst in an exhilirating period of growth. I felt that through my openness to personal work I could offer women clients a shared therapeutic experience which would counterbalance my inexperience as a therapist. In this stance, I had the support of the feminist model of therapy, which states that women clients should see women therapists because only a woman can understand another woman's experience. I was prepared to strongly identify with my clients,

and to use the intimacy granted by our shared experience in our therapeutic work.

My first client, Nancy, was a 26 year old woman who had transfered from a male therapist she had been seeing for two years. I plunged headlong into an identification with her, based on our shared pattern of seduction as a means towards the end of avoiding our own painful experience. This was a theme I had been working on, and I was convinced that our needs and patterns were identical. The identification was in part a competitive stance towards her previous therapist: yes, they had an intense and tempestuous therapy, and yes, he was more experienced than I was, but after all he was only a man, and couldn't know her from the inside the way I did. I was overinvolved with Nancy far before our first session, and was counting on identification as a therapeutic shortcut.

To my eye, our first session seemed spectacularly successful. She and I acknowledged our bond as women and proceeded to dispense with her male therapist, whom she had seen for the last time only a week before that point. I assumed that just as I had gotten free of my old, dependent, seductive ways she too would shed the constraints of the feminine stereotype and join me on the pinnacle of androgyny. My absorption with my own experience obscured the exploration of hers, which was our therapeutic work. Nancy needed to work through her termination with her male therapist and the paternal relationship underlying it. She also needed to acknowledge and work through her feelings of hostility and competition towards women, and the maternal relationship underlying it. My stance of identification

served two distinctly self-protective and countertherapeutic functions: it obscured my awareness of my inexperience, and sensored areas of discussion which I wasn't ready to deal with. The outcome was that she terminated the therapy after four sessions.

I would describe my experience with Nancy as representative of the first developmental stage which Werner outlines. While I had begun to integrate an androgynous model into my personal work, steps toward integration had to begin anew in the face of a new situation with new demands. I had an egocentric and fused perception of my first client, and did not have the opportunity to progress beyond that stage within the context of the therapy. I was painfully aware that I had come inappropriately close to Nancy and proceeded to move inappropriately far from the clients who followed, thus moving to the second stage of polarities.

In this second stage of my development as a therapist, I moved to the beginnings of a differentiation of myself from my clients. I had been burnt by my experiences with complete fusion and identification, or else I might have lingered in my egocentric infancy a while longer. Instead, I graduated to egocentric childhood: I moved from fusion to the beginnings of differentiation, but in a position of exagerated distance which remained inflexible. The exageration was directly proportional to the degree of vulnerability I was feeling. I was willing to purchase stability at all costs. The experience was too painful, and too early in my development as a therapist, for me to fully acknowledge the crisis of competence it had triggered. Instead, I retreated to the comfortable polarity of intellectual distance

and abstract conceptualization which was so familiar to me as an academic.

At that point, I began working with a couple in their early thirties who were transfered from a couple's therapy with male and female co-therapists. The earlier therapists warned me that the wife would expect a female therapist to take her side, that she would cling to me and become very dependent while the husband would retreat into the woodwork. My supervisor and I discussed the importance of learning to regulate distance from clients, and I decided that I would carefully monitor distance. The polarity of distance rigidified very early in our work, as the powerful dynamics in the couple's therapy met up with my self-protective resolution of the earlier developmental crisis. I struggled to maintain distance from the wife, which intensified her attempts to pull me in on her side. She insisted that she had done her share of personal work, that he was refusing to take responsibility for his part in the relationship, and it was now his turn to change. Had I not traversed a full pendulum swing away from my androgynous consciousness, I might have recognized at that point a classical sex-role pattern in their marriage. She was housing all the emotion and all the dependence, and had once been hospitalized under the pressure of this. This freed him of the need to experience his own emotions, his own childish needs, and enabled him to withdraw in the face of her pursuit. I continued, inflexibly, with my statement that she had to take responsibility for her own therapeutic work and let him do the same for himself. We became locked into an angry battle, in part because my carefully regulated self-protective stance was again preventing me from hearing her experience.

This time, I was steadfastly refusing to identify with her, refusing to acknowledge that her part in the relationship was familiar to me from my own experience.

The tension in the therapy continued to build for four months, as did her anger at my distance. At that point, she insisted that her anger at me was justified, that I was unsupportive and not to be trusted with her experience, and insisted on terminating the therapy. I asked Sandy to come in as a consultant for a final termination session because I felt I needed an outside view of the situation and also because I felt she could provide the warmth and support I had been unable to give. My own warmth and spontaneity was unavailable to me within the adaptive style I had chosen.

The termination began the move toward the third stage of integration, because it gave me the freedom to examine the experience without being overwhelmed by the intense feelings in the relationship. I experienced a crisis of competence, in which I became aware of the rigid and self-protective stance I had taken. At least part of the pain of that time was the price of retreating into that distant and overly rigid stance to ward off a crisis after my first client. Fortunately for my learning, not to mention my self-esteem, the couple decided to resume our work after we had all reflected for a month. Because of this, I had the opportunity of consolidating my learning and growth through the continued therapy, and providing them with the benefit of that. I feel that in the second stage of my work with them, I have begun to move towards greater androgynous integration in

my therapeutic style. I felt comfortable being more emotionally spontaneous and available, but also felt comfortable maintaining some necessary distance from their emotional experience. I have also been able to move to a more androgynous conceptualization of their relational dilemma. Where at an earlier point I had shifted blame for the situation from one spouse to another, precisely as the couple was doing, I began to work from a view of their mutual contribution which helped them do the same.

I can't report a happy ending to this developmental tale. Life goes on, with its new situations and new demands that throw the delicate equilibrium into turmoil again. Werner doesn't mention this, but this business of growth and development is as often painful and chaotic as it is rewarding and exhilirating. There are no guarantees that new resolutions will be more adaptive than the old. Judging from my experience after my first client, if the chaos is too intense stability may be purchased at the expense of growth. I am by no means finished with crises of competence as a therapist. While I recognize the unfolding of developmental sequence in my work, I still find it difficult to accept my own early stages of development. I will undoubtedly continue to present my early work as I have done today, with a critical and unforgiving eye. This will necessarily interfere with my ability to help clients accept their own childishness as a natural step in growth. Lacking a happy ending, I hope that this developmental analysis of my first clinical practicum has offered you something which will help you come to terms with your own experience, as it has helped me with mine.

Moving Toward Androgyny: Illustrations from one Group's Process

Roslyn K. Malmaud

At this point you have been introduced to every member of a psychotherapy training team. Much has been said about individuals' struggles to incorporate and balance stereotypically defined sex-linked traits in themselves and in their relationships with clients. What I would like to share with you is my perception of how we functioned as a group, and more specifically, how our mutual interest in the model of androgyny for mental health affected us. My unique role on this team was that of a clinical associate, supervising the therapy of several team members, and observing the group meetings with an eye towards its process and progress. I was, nonetheless, also a member of this team.

Issues and conflicts that exist in any group were also apparent in the evolution of this one. Yet we were somewhat unique, because each clinical trainee electing to join this group knew that the team leader had a major interest in the model of androgyny and the effect that the awareness of sex-roles has on therapists. Second, we are all women, and third, the majority of our clients were young women. Subsequently, we agreed to strive for androgyny in ourselves and in our clients. Here we encountered a potential problem. We embraced the <u>idea</u> of transcending our sex-role, but had only subjective impressions of what the outcome would be. This goal that we set for ourselves proved unreachable, and maybe even created problems. One example, drawn from the first stage to evolve will illustrate this phenomenon. The spirit and enthusiasm generated by the team leader gave us an initial feeling of unity and

commitment, and a sense of pseudo-intimacy developed. But as the team moved towards intimacy, some members became frightened. Consequently, people vacillated in their engagement with others; almost every one withdrawing at times, or becoming hostile. Once the issue of intimacy became overt, we looked for underlying reasons. We acknowledged our multiple and complex goals, and the reality that teammates had very different needs. All of us are relative neophytes as therapists. As a supervisor, I encountered the varying styles people assume when faced with this new situation. Some individuals plunge in armed with techniques and theories derived from books. Their knowledge eases their anxiety. Others grapple with the emotional impact of the therapeutic relationship. Some are reluctant to speak of their fears, and revert to an area of comfort such as academic discussions. Although I have simplified the strategies used by clinical trainees, in more complex patterns they were manifest in the supervisory group. Common to any group of this sort, a struggle is implicit in attempts to accommodate needs and styles. In our group, perhaps, the variations in style were masked by people's needs to appear competent. In the research on sex-linked characteristics, professional competence is usually associated with masculine traits. Consequently, I believe, in the group situation members hid their insecurity about doing therapy. Had the initial closeness been more substantive, we would have trusted each other more with our vulnerabilities without worrying if we would be considered less androgynous people.

The issue became more focussed in the next phase of the group, when we recognized the opposing pull to focus on personal versus professional issues. This was not only an internal but an interpersonal struggle for the group members. Clients' problems often touched on private concerns, particularly since many of our clients were young women. We struggled in our discussion of such issues as dependency and relationship problems, in a way that would be not only helpful to the therapist, but also to team members. This involved a compromise between personal needs and the group's need to function as a training forum for neophyte therapists.

This conflict was resolved smoothly by establishing time limited discussions in which we considered the actual case before extending the salient theme to ourselves. We had found a means to use our personal issues to enhance our professional conceptualizations. We could move from theory to application, then use applied work to reassess the theroy. Because the struggle between personal vs. professional issues could be operationalized, handled by time limited discussions, we were able to resolve this dialectic. We had recognized that the personal concern <u>is</u> professional, and could be balanced.

In contrast, the tension between competition and support among group members seemed more resistant to synthesis. Ideally, we sought an androgynous solution, offering each other constructive criticism tempered by caring. This quest seems to be necessary in any group fostering growth and development. What emerged instead was a critique performed in a subtle, manipulative manner. Intellecutal sparring was

common, and we often interrupted each other and failed to listen to one another. The ability to display or request support became submerged in the process. Upon close inspection, sarcasm was disguised by humor, and by duels to ascertain whose wit was quicker or sharper. Constructive criticism had sadly been lacking or had been deflected. Clearly, our behavior could be seen neither as androgynous, nor as mutually satisfying to team members. It seemed even progress toward androgynous behavior was subject to competition. And yet, given the awareness of our goal to strive for androgyny, we began to critically explore our process. We realized that our aggression and competition with each other were displayed in masculine and feminine styles, but not at a midpoint. Then again, we had lost the quality of compassion and support-giving that had been present. Quite possibly traits like sensitivity and softness were belittled because they were rooted in the stereotypic feminine personality. We acted as if we assumed that sharing is a feminine trait and competing is a masculine characteristic, rather than emphasizing the degree of these traits ideally found in both sexes.

This issue was highlighted when we gave ourselves Bem's scale of masculine and feminine characteristics, but we were not ready to express our feelings about one another's integration of sex-role traits. At the time, this would have been threatening. What first became apparent was our false sense of comradery, which was founded in our being women concerned with women's issues. As a group we stood out in the department, but among ourselves differences became sharper. As the group moved through its first two phases there seemed to have been a lack of or deferred respect

for individual differences. By midyear teammates began to share variations in therapeutic style and approaches accumulated from past experiences. The essential ingredient in this form of sharing was the individuals' feeling of security in their unique identities. The stronger this was, the less members felt differences to be undermining their own positions.

Another issue which was inherent in the subtle competitiveness among us stemmed from ambivalent feelings regarding closeness. Of all the tensions or dialectics faced by this group, feelings about intimacy were the most pervasive and unwieldy. To be close to others in the group involved a degree of exposure, concommitant with an internal feeling of helplessness and vulnerability. Initially we recognized that many of our female clients felt helpless, but were not able to ask for assistance. We realized this dilemma was true for us, as well. Months later, in an emotionally charged meeting, our inability and awkwardness in helping a peer became evident. To receive support, one had to act excessively needy. The bind we created was that while we all needed support, we were reluctant to display our vulnerabilities. In addition, the helpgivers reported some anger, for they also had needs that were not being attended to. In retrospect, the conflicts were evident on several levels. Each individual had to decide to be strong or weak, a helper or receiver of help. The group had to choose whether to support a member with a personal problem or to attend to the scheduled, professional agenda. Once again, let me stress that a fear of closeness and a desire not to appear vulnerable is common in any group.

But due to our confusion about the personification of androgyny, we may have delayed in expressing these fears, since they were experienced as weaknesses, associated with stereotypic feminine behavior.

The turning point towards a resolution of this conflict occurred in March. First, we all participated in a workshop with an outside leader. People made the most of this situation by self-disclosing, reaching out and finding and giving supports. Second, the team leader established a weekly open house evening at her home, which encouraged people to socialize and allowed for an open expression of friendship and warmth. Individuals' needs for support being satisfied, meetings in the clinic became more professionally oriented, unclouded by personal issues. Without ambivalence, we could share the joy in another member's job offer or academic success. In retrospect, the addition of this second weekly meeting resolved one dialectic.

The final months of our group were productive and emotionally rewarding. However, the issue of termination was deferred, and the closing session delayed. Perhaps people sensed there was no closure on our initial purpose, that is, to move towards androgyny in ourselves. Not certain that we had obtained this goal, the group's ending was handled by the expediency of the academic calendar.

As the semester drew to a close, we reviewed our group's development. We concluded that while we would like to think of ourselves as integrated, in terms of the model of androgyny, when interpersonal issues, fears, and inadequacies threaten our sense of resolution and strength, we revert to

polarized stages. Some may fall back on the very thing they are trying to transcend, the stereotypic ways of behaving as a woman. Others go to the other extreme, and become caricatures of men. As a group, we had not demonstrated consistent transcendence of sex-typed modes of behavior. But we had, consistently, showed an effort to re-evaluate our progress.

In conclusion, this psychotherapy team lent itself to a series of conflicts, resolutions through synthesis, then other conflicts, because there were no clear, pre-established, formal modes of operating given the androgynous model. The self-learning implicit in ongoing groups offers considerable learning and intensity. This is true <u>because of</u>, rather than <u>in spite of</u> the struggles. Still, a balance has to be established between the intensity and comfort of a group. Support must be woven in with the intensity. In the face of forever existing struggles, oases of laughter and good humor become necessities. Yet a balance between fun and work must slant towards the latter in a climate of introspection and self-growth. Had we avoided struggles more through the year, quite definitely the cost would have diminished personal growth and professional thinking.

...SUNDAY AFTERNOON

...of the *Journal of* ...Psychology

...Two Hundred Years Tell Us

...Evolution of Undergraduate

Division 16

...Incorporated James Eikeland, ...and William H. Farling, Miami Univer-

Division 16

...Programs for Potential High-Risk ...Medical Center, New York University, chair

...Education, Northeastern Illinois ...Identification Programs for High-Risk

...Center, State University of New York Col- ...Identification Programs

...Medical Center, New York University, Early

Divisions 22 & 18

...Knowledge of Rehabilitation Through Research ...Dept. of Rehabilitation Medicine, Goldwater ...Center, New York University, Roosevelt Island, chair

...Monroe Community Hospital, Rochester, N.Y.

...and Rehabilitation in Clinical Psychology Training Pro-

...Health Training Center, Los Angeles

...Method as an Educational Tool in Rehabilitation

...Rehabilitation Foundation, Santa Barbara, Calif.

...Research Utilization

...Rehabilitation Medicine, Goldwater Memorial Hospi- ...York University, Roosevelt Island, N.Y. Consumer Af- ...in Rehabilitation

...Workshop, Inc., Wilmington. Thera-Flicker ...in Rehabilitation

...Room, Sheraton Park **Division 23**

...in Consumer Psychology Howard G. Schutz, Dept. ...University of California, Davis, chair

...of Energy-Related Consumer Information. Robert A. ...Amy Lubitz, William Fisher, and Jacob Jacoby, Purdue

...Choices on the Risky Shift. Peter H. Reingen, Dept. of ...

...For-Spouse Decision Sets on Consumer Risk Taking. ...of Marketing, University of Chicago

3:00 SUNDAY AFTERNOON

3:00–4:50 continued

Attitude and Behavioral Structure Analysis of Consumer Brand Choice: Replication. William O. Bearden, Dept. of Marketing, Western Kentucky University, and Arch G. Woodside, Dept. of Marketing, University of South Carolina

Recognition of Rational Versus Emotional Appeals in Magazine Advertising. David E. Anderson, Allegheny College, and Richard B. Kaufman, Syracuse University

Readability of Written Materials Used in the Food Stamp Program. Warren S. Blumenfeld and Sharon L. Morris, Dept. of Marketing, Georgia State University

Discussant: Michael Ryan, Dept. of Marketing, Columbia University

3:00–4:50 **Club Room B, Shoreham Americana** **Division 26**

Symposium: Happenings in the History of Psychology John A. Popplestone, University of Akron, chair

3:00–4:50 **Map Room, Washington Hilton** **Divisions 29 & 35**

Symposium: Process of Sex-Role Integration in Psychotherapy Alexandra G. Kaplan, Psychological Services Center, University of Massachusetts—Amherst, chair

Participants: Bobbi Fibel, University of Massachusetts—Amherst. Transcendence of Sex Roles: Parallel Cultural and Psychotherapeutic Change Processes

Mary Anne Sedney, University of Massachusetts—Amherst. Complexities in Conceptualizing Clients' Problems in Androgynous Terms

Anne McComb, University of Massachusetts—Amherst. Exploring the Nurturance Needs of Independent Women in Psychotherapy

Ann C. Greif, University of Massachusetts—Amherst. Developing an Androgynous Perspective Within the Client–Therapist Relationship

Ester Shapiro, University of Massachusetts—Amherst. One Person's Therapist Is Another Person's Client

Roslyn K. Malmaud, University of Massachusetts—Amherst. Moving Toward Androgyny: Illustrations from One Group's Process

Discussant: Barbara Oleshansky, University of Michigan

3:00–4:50 **Lincoln Room West, Washington Hilton** **Division 31**

Discussion Session: Trends in Health Care—A National Perspective Patrick H. DeLeon, Office of U.S. Senator Daniel K. Inouye, Washington, D.C., chair

Participants: Stanley Jones, U.S. Senate Subcommittee on Health, Washington, D.C.

Robert McGarrah, American Federation of State, County, and Municipal Employees—AFL-CIO, Washington, D.C.

Nicholas A. Cummings, California School of Professional Psychology, San Francisco

George Stricker, Institute of Advanced Psychological Studies, Adelphi University

Discussant: Logan Wright, Div. of Pediatric Psychology, University of Oklahoma Health Sciences Center, Oklahoma City

3:00–4:50 **Caucus Room, Washington Hilton** **Division 33 & 25**

Symposium: Behavioral Management Information System for the Developmentally Disabled William I. Gardner, Dept. of Studies in Behavioral Disabilities, University of Wisconsin—Madison, chair

Participants: Jeffrey L. Crawford, Rockland Research Institute, Orangeburg, N.Y. Using Automated Information Systems to Deliver, Monitor, and Evaluate Treatment

Anthony Epworth, Rockland Research Institute, Orangeburg, N.Y. Assessing

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